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ABSTRACT

Patients' rights legislation makes the determination of possible danger to self and others extremely important for patients about to be discharged from mental institutions, especially patients who were admitted because of suicidal behavior. Because evaluation methods which rely on patient self-reports may be manipulated by clever patients, a new word association technique was developed for use in the determination of suicide risk. The list of stimuli may include words which express feelings; relate to aspects, areas, or stages of life; or are indicative of significant interpersonal relations. While stimuli lists are formed with some freedom, three words are usually included in all explorations of suicide: future, hope, and death. Subjects are instructed to react with three different ideas or thoughts to each stimulus. Hospital inpatients (N=34) who had attempted suicide or had presented serious suicide ruminations or threats were administered the word association test. Tests were scored blindly by two judges. Scores were then compared to a categorization of the patients as suicidal or non-suicidal made by psychiatrists with full access to each patient. The test correctly identified 82% of the suicidal and 94% of the non-suicidal subjects. A 5-month follow-up provided additional support for the test. Test results may provide information about a patient's risk and the motivations that led to self-destructive behavior. (References and three samples of the technique are appended.) (Author/NB)

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DETERMINING SUICIDE RISK USING A NEW WORD ASSOCIATION TECHNIQUE

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Abstract

A clinical application of a new word association technique is described. The list of stimuli may comprise words: a) expressing feelings, b) related to aspects, areas or stages of life, c) indicative of significant interpersonal relations. The key words are: future, hope and death. Subjects are instructed to react with three different ideas or thoughts to each stimulus. The test results may provide information about: a) the patient's risk, b) the motivations that led to self-destructive behavior. Validation: 34 patients who had attempted suicide or had presented serious suicide ruminations or threats were tested. Tests were scored blindly by two judges. Scores were compared to a categorization of the patients as suicidal or non-suicidal made by psychiatrists who had full access to each patient. The test correctly identified 82 % of the suicidal and 94 % of the non-suicidal subjects. A five month follow-up provided additional support to the results of the test.

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DETERMINING SUICIDE RISK USING A NEW WORD ASSOCIATION TECHNIQUE *

Current patients' rights legislation makes the determination of possible danger to self and others extremely important for those clients who are about to be discharged from a mental institution. This is a particularly delicate problem in those cases where the patient was admitted to a hospital because of a suicide attempt or a serious suicidal threat.

A clinical history of self-destructive behavior should not be used as a safe guide for judging the degree of risk because, even in the case of a highly lethal attempt, a few hours or days after the suicide attempt, the patient may no longer be suicidal. This may be due to many different factors, such as (a) the subjective effect of the experience, (b) a change in the behavior of the significant persons in the patient's life because of the attempt, (c) a successful crisis intervention, etc.

Although traditionally this problem has been solved by means of a psychiatric interview, frequently psychiatrists need more objective proof of the patient's degree of suicidal risk. Unfortunately the results obtained with the traditional tests have not proved very encouraging in the accurate prediction of suicidal tendencies or risk (Neuringer, 1974 a).

Some MMPI scales have been able to differentiate between groups of suicidal and non-suicidal patients (Leonard, 1977; Peniston, 1978; Watson, Klett, Walters & Laughlin, 1983); but discrimination at the individual level does not seem to be presently possible (Clopton & Jones, 1975; Engelsmann & Ananth, 1981). The results obtained using the Rorschach test are similar. Some articles claim to have found significant differences between groups (Exner & Wylie, 1977; Rierdan, Lang & Eddy,1978; Kendra, 1979; Arffa, 1982); but a safe application to individual cases is still elusive (Neuringer, 1974 b; Farberow, 1974; Kestenbaum & Lynch, 1978; Smith, 1981).

The most accurate psychological instruments presently available are the scales that have been developed in the last few years in the United States and in Britain, such as: the Hopelessness Scale (Beck, Lester & Trexler, 1974); the suicidal Intent Scale (Beck,Morris & Beck, 1974); the Scale for Suicide Ideation (Beck, Kovacs & Weissman, 1979) and the scales published by Pallis, Gibbons and Pierce(1984).

As often happens with questionnaires and scales based on verbal self-reports of patients, manipulation by a clever subject is always possible. The responses to projective techniques may also be the result of a deliberate falsification on the part of a patient, but it is a more difficult task. This was the reason that has suggested the possibility of using a new word association technique in the determination of suicide risk.

Traditional word association techniques (Jung,1918; Kent & Rosanoff, 1910; Rapaport & Schafer, 1946;...) require the subject to respond with a single word to a series of words that function as stimuli. On the Tavistock Word Association Method subjects are asked to respond to a series of stimuli with a single sentence (Sutherland & Gill, 1970). The main innovation introduced here consists of instructing the subject to respond (a) with three different thoughts, (b) which might be expressed by a single word or by a sentence. The rationale for this change is the following: the subject's defenses may be more weakened when pressed to react with three different responses for each stimulus-word. The list of stimuli is not fixed but tailored to each subject's situation and characteristics.

Population

Thirty four hospital in-patients served as subjects for this study. They were selected from a large pool of patients who had been hospitalized because of a suicide attempt or a serious suicide threat and had been administered the word association test that is here described.

(*) Research conducted at Crownsville State Hospital, Crownsville, Md.
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The experimental group(Suicide risk, Group SR) was formed by 17 patients who were judged a suicide risk at the time of the testing by psychiatrists who based their opinion on a) the clinical history of the patient, (b) the result of a psychiatric interview; (c) the circumstances and lethality of the suicide attempt (place, method, and chances of being helped); (d) the history of previous attempts, if any; (e) interviews with the patient's relatives; (f) a detailed account of the suicide threat, if this was the case.

Group SR patients were matched on the basis of sex, age, diagnosis and suicidal behavior to a control group of 17 subjects who were not considered at risk for a suicide attempt (Group Non SR) at the time of the testing. There were 9 females and 8 males in the group SR, and 10 females and 7 males in the group Non SR. The mean age was 30.6 years for the former group, and 32.0 years for the latter group. The diagnoses were exactly matched for both groups: 4 schizophrenias, 2 psychotic depressions, 8 non-psychotic depressions, and 3 drug abuse cases. In both groups, 12 patients had attempted suicide and 3 had made a serious suicide threat or were hearing voices telling them to commit suicide.

Procedure

1. Instructions.

Clients were informed that the psychologist was going to read them a series of words, one at a time. Following presentation of the words, subjects were instructed to give three verbal responses. They were supposed to say the first thing that came to their minds, and could express their thoughts by single words or by sentences. These reactions (they were told) might or might not be related to their personal lives.

2. The list of stimuli.

The list of stimuli for this technique may include: a) words expresing feelings, like "fear", "wish", "hatred", "love",...; b) words related to aspects, areas or stages of life, like "childhood", "marriage", school", "work", "sex",...; c) words indicative of family relations, like "family", "my father", "my mother", "my spouse", "my children",... This list is formed with a certain degree of freedom, taking into account the concepts that the psychologist wanted to explore, based on the information which they had at the time of the testing. Three words are usually included in all explorations of suicide: "future", "hope", "death". "Myself" and "suicide" in some cases may be also be added.

3. The interpretation of the tests.

The word association test presented here serves two purposes: (a) to determine the degree of suicide risk at the time the subject is tested, and (b) to afford some indications of patient's conflict areas which might have played a role in the suicide attempt or the suicide threat and which could lead to a succesful self-destructive act sometime in the future.

The test results can, therefore, be used secondarily in an in-depth interview with the client geared to a possible clarification of the forces underlying the subject's suicidal reaction. However, the present study is circumscribed to considerations of the validity of the instrument in order to the determination of the degree of suicide risk at the time the client was seen, mainly based on the key words "future", "death", and "hope".

4. Scoring of the tests.

Two psychologists who had never seen the patients and had no other information about them other than their age and sex, rated each test on a scale of 6 points, from definitely suicidal (6) to definitely non-suicidal (1).

Results

1. Reliability

The inter-rater reliability of the two judges was: .82.

2. Validation of scores.

Individual scores for clients were computed by averaging the scores asigned to each subject by the judges. These scores were then compared to the psychiatric classification (i.e., suicidal risk vs non-suicidal risk), asigning (4) as the cut-off score.

The results of the exercise were: Fourteen (14) successes or hits for the suicidal group and sixteen (16) hits for the non-suicidal group. The test was able to correctly identify 82 % of the suicidal and 94 % of the non-suicidal patients ($\chi^2 = 20.16$, d.f.= 1, $p < .001$).

Although the test scores were not intended to be interpreted as long term predictions of suicidal behavior, it is interesting to notice that in a follow-up of the 34 patients in the group, five months after the administration of the test, it was found that 3 of the 5 patients who had obtained a score of 6 had attempted suicide again. A fourth member of this group did not attempted suicide as such but had to be readmitted to the hospital within 5 months of test administration because of a serious self-mutilation attempt. The fifth member of the high score group was doing well in the community. These figures may be compared to the presence of only 2 cases of suicide attempt among the 29 patients with a score of 5 points or less ($\chi^2 = 15.6$, d.f.= 1, $p < .001$). It may also be noticed that in one of those two cases, the psychologist who administered the test wrote in the corresponding report that because of the nature of the conflicts and the lack of support systems, the patient was a likely candidate for another suicide attempt.

Conclusions

The word association test described in this paper may be used as an objective counterpart to a clinical interview for the determination of suicidal risk. The amount of time required by the administration and interpretation of the test (usually no more than 15 minutes) makes this procedure an economic tool in clinical practice.

This technique may also serve as a valuable tool in therapy, because of the additional information it may provide, such as identification of (a) conflict areas that might lead in the future to another suicide reaction, and (b) motivations that the client may use to fight the suicidal tendencies.

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THREE SAMPLES OF THE TECHNIQUE

1. A SUICIDAL PATIENT

Male, 36. Single. Profession: Teacher. Has recently lost his job. Lives by himself. Paranoid schizophrenia. The client has been hearing voices telling him that he should kill himself.

1. Book. Learning. Friends. Education. -Why did you say friends? -Books are good friends..
2. Childhood. Very lonely. Unhappy. Unpleasant.
3. Future. Future? I don't know anything about that. -What do you mean? -Who knows the future? (Silence). Future? I guess I should say I want the future to be happy.
4. Family. My sister. (Silence). Family is something I don't know anything about. Just try to guess what a family looks like, trying to live that way.
5. Fear. Fear? I guess, fear of dying. Fear of not being able to make it, to live decently. Economic fear. -Why did you say "fear of dying"? -I don't guess anybody likes to die, but sometimes it is necessary. -Why "necessary"? -For some people it's the best solution to their problems.
6. Women. Good friends. (Silence). Women?... Sisters. I guess, mothers.
7. Wish. I wish I was dead, but I feel I can't do that. "Wish" is something people have when they are unhappy. I guess... I wish I wasn't so sick.
8. Sex. Necessary. Good, I guess. I think of men when I think of sex. It's pleasant and enjoyable. (Silence). Sex leads to a lot of problems. In my case I have not adjusted myself to homosexuality. Should not be there, but it's there.
9. Job. I hate it. I guess I never told this before. I lost something when I lost my teaching job: the prestige, the sense of helping somebody else.
10. Love. I guess, that's the cure all for everything. But I don't know what love is. A full love relationship I never had.
11. Death. Relief. Rest. Unknown.

Notice: the homosexual conflict (8), the absence of family support (4), the lack of "a full love relationship" (10), the loss of his teaching job, The client does not see himself as a person who is able to commit suicide (7), but his death wishes (7, 11), his justification of suicide as a "necessity" (5), and the complete lack of support systems make him a suicide risk.

Two months later, after psychotherapy and a change of attitude on the part of his family, the client was no longer suicidal. Antipsychotic medication was also a part of the treatment.

1. Book. Libraries. I like to read. An education. Relaxation.
2. Childhood. Unhappy. In the past. Something to learn from. -Why did you say "in the past"? -It's past, all over.
3. Future. Uncertain. Want to get a job, may be in printing. May be later on will get a professional job.
4. Family. Brothers and sisters. Love. Lots of support.
5. Fear. Fear of the unknown. Has a lot to do with the future. It's a natural fear. -What do you mean? -Financial: how to make a living.
6. Women. Good friends. Each woman is different. Competitive. -What do you mean by "competitive"? -My fear of extending myself, my fear of loving.
7. Wish. I wish that everything turns out OK this time. Wishes are something to be worked out. I guess I wish to do something that makes life better. -In what sense? -For myself and other people.
8. Sex. Something enjoyable. I guess, a necessary thing (smiles). That's all about it.
9. Job. To get a job. I want to get a job that will make me happy, although I cannot do it right away. A job is a way of fulfilling yourself.
10. Love. Something to work for. Something that is given without being asked. Like my brothers and sisters. Something not everybody has.
11. Death. We all have to die. The death of people you love can be very painful.

2. A DEPRESSED PATIENT, BUT NOT A SUICIDE RISK

Female,45. Teacher. Temporarily unemployed. Married for the first time in her life a few months before being admitted to a mental health center. Her marriage was a failure. Diagnosis: a major depression. Good relationship with her sisters.

1. Book. Reading. Using books to teach my children in school. Enjoying reading.
2. Family. Large family. Supportive family. Caring family.
3. Future. Right now: empty. I know that I may get well,but I can't feel that way. I have no goals.
4. Childhood. Unhappy and happy. I don't think I felt loved. My mother always had her mother. All she did was for her mother. We had to be respectful for my grandmother and my father.
5. Death. Sad. Sometimes I feel my father will die, because he is 82. Sometimes I feel death is the only solution that may get me out of a depression, but that's not realistic.
6. My father. Very strict, a good man, a caring man.
7. Wish. I wish I were well. I wish I did not go through this depression (patient cries). Sometimes I wish I was not ever born, but this is not a permanent feeling.
8. My mother. She cares about me since her mother died, but she is not affectionate. She hates being at home. Two saturdays ago it was the firsttime that I said to my mother that I loved her.

The patient is obviosly depressed (3,7) and has had some suicide ideation (5,7)but does not seem to be seriously suicidal. Her first associations to "death" were related to the death of other persons. She acknowledges having death wishes (5,7) but they are "not realistic" and do not constitute "a permanent feeling".

After a successful psychiatric treatment, exclusively based on antidepressants, the client was sent back home. Her conflicts are still present in her mind (4,7,8) but the death wishes have completely disappeared (5) and the depressive crisis is over (3,7). These were her responses to the Word Association Test on the day she left the mental health center:

1. Book. Read. Interesting. Enjoy.
2. Family. Helpful. Supportive. Loving.
3. Future. Happy. Looking forward to. Work.
4. Childhood. Hard. My father and mother were very strict. Not too understanding.
5. Death. The ultimate end. Sad. Morbid. -Why did you say"morbid"? -Scary. Frightening.
6. My father. Strict. A good person. He cares.
7. Wish. I wish never to get depressed again. I wish a good health for my family. I wish a smooth solution for what is ahead of me, especially my divorce.
8. My mother. Too attached to her mother when I was growing up. It was only recently I told my mother that I loved her. She told me she loved me too.

3. CLIENT WAS NOT A SUICIDE RISK, BUT...

Female, 27, housewife. This client was hospitalized in a community mental health center after a very serious suicide attempt.
On the day she was discharged she was not considered a suicide risk, but it was understood that she was going to see a private psychologist on a regular basis. Unfortunately, this did not happen, and one month later she attempted suicide again.

This was her Word Association Test:

1. Book. Beautiful. Interesting. Green. -Why "green"? -Some books have a green cover (?).
2. Family. A large family. I want to be reunited with my family. My family is a good family.
3. Future. We all shall be reunited again. I have faith in the future. In the future I will be all right.
4. Death. I am afraid of death. Death leads nowhere. I am not going to think of death any more.
5. Marriage. (Long silence). I' like my marriage to be happy. My marriage will be happy if I try it to be happy. I don't want to destroy my marriage.

6. Fear. I am afraid of life. I am afraid of death. I am afraid of darkness.
7. My husband. Very good. Hard worker. He loves me.
8. Sex. (Long silence). (Client has tears on her eyes). I don't know. I can't... Sex is not attractive to me. I don't like to have sex.
9. My son. Healthy. Loving. Handsome.
10. Myself. Good for nothing. I am a useless person. I am not a wife. But now I see myself as capable... capable of taking care of my child.
11. Work. I want to work. Working keeps occupied my mind. Working will cure me.
12. My parents. They will come soon. I need to see my parents. I love my parents very much.

This is a summary of the psychologist's findings based on the test:

On the day she was tested, the client was not a suicide risk. She said that she was "not going to think of death any more" (4). She was "afraid of death" (4,6). She was also able to think of her future in a positive way (3,5,10,11).

But she still had 3 very serious emotional conflicts:

A) She was supposed to come to the States with her husband and child and with her parents, but, because of an unexpected decision of the political police of her country, her parents were prevented from accompanying them. All her life the client had been an extremely dependent person (she continued living with her parents after marrying) and was continuously obsessed with the idea of being reunited with her parents (2,3,12).

B) She has a positive image of her husband (7), but her marriage is a complete failure from the point of view of sex (8, 10).

C) Her self-concept, especially because of her sexual conflict, is pathologically poor (10).

The client's main reasons to live are: a) her responsibility as a mother (10); b) her idea of being able to live with her parents again (3).

An intensification of her marriage problems (8, 10), of her "fear of life" (6) or the idea that her parents will not be able to come to the U.S. will probably be "the breaking point" for another suicide attempt.

This was what, unfortunately, happened a month after she was administered the Word Association test. She was able to survive but had to be hospitalized with very serious lesions for more than 2 months. The psychiatric diagnosis was: major depression with psychotic features.

Note: Cases 2 and 3 were not a part of the research conducted at Crownsville. They were seen at the Miami Mental Health Center, Miami, Fla.